Desert Pediatrics

7180 Cascade Valley Court #180 * Las Vegas, Nevada 89128 * Phone (702) 641-2150 * Fax (702) 228-1043
2150 S. Eastern Avenue * Las Vegas, Nevada 89104 * Phone (702) 641-2150 * Fax (702) 641-8667

This request to OBTAIN medical records will be returned if not completed in its entirety.

Patient Name: ____ Medical Record Number: ___________

Address: ______________________________ City: _____________________ State: ____ Zip: _______ DOB: _________

1. I HEREBY AUTHORIZE ____

TO DISCLOSE

		Phone Number:
Address	City, State, Zip	Fax Number:

THE ABOVE NAMED INDIVIDUAL'S PROTECTED HEALTH INFORMATION AS DESCRIBED BELOW:

2. The type and amount of information to be used or disclosed is as follows

Include dates where appropriate: **FROM** (date) **THROUGH** (date)

☐ Entire Record, or:

[ ] Medication List [ ] Immunization Record [ ] Provider Notes

[ ] Laboratory Results [ ] X Ray/Dexa Reports [ ] Consult Notes

[ ] Other ____

3. IF PRESENT, I GIVE PERMISSION TO RELEASE ANY SENSITIVE INFORMATION REGARDING: (Initial on Applicable Lines Below)

_____ Substance Abuse _____ Psychiatric / Mental Health Information (To Include Dates Seen In Office)

_____ Genetic Test Results _____HIV Information _____ Addictive Behavior _____ Child & Domestic Abuse History

_____ Communicable & Sexually Transmitted Diseases

4. REASON FOR REQUEST: Continuing Medical Care

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign the form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department and obtain a copy of the Privacy Notice.

THIS INFORMATION IS TO BE DISCLOSED TO:

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Signature of Patient / Parent / Guardian or Personal Representative: ____

Relationship: __________________ Date: _________________

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ____

The company does not discriminate in health programs and activities.

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PLEASE NOTE:

- Requesting records on behalf of our patients for continuing medical care is done as a courtesy. We do not pay for records requested from previous providers. If payment is required, please obtain directly from the patient.
- If possible, please send requested records on CD, preferably in Adobe Acrobat format.

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